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## Standards for Payments


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# 50.000 Standards for Payments

This chapter provides information on claims and encounter submission and receipt of payment by CRS contractors for services rendered under the CRS Program.

# 50.100 Scope of the ADHS' Liability for Payments to Contractors

1. The ADHS shall bear no liability for the provision of CRS services or the completion of a plan of treatment to any member or eligible individual beyond the date of termination of such individual's eligibility and enrollment.
2. All payments to contractors shall be made pursuant to the terms and conditions of contracts executed between contractor and the ADHS, and in accordance with Administrative rules.
3. CRS Regional Contractors are responsible for any and all subcontracts executed with other parties for the provision of either administrative or management services for the CRS Program, medical services, covered services or for any other purpose.

# 50.200 Claims Submission

1. CRS Regional Contractors shall develop and maintain claims payment systems capable of processing, cost avoiding, and paying claims. For claims submitted for state-only payments, claims submission deadlines shall be calculated from the date of service/date of discharge. For AHCCCS covered claims, the submission deadline shall begin with the date of service/discharge or, in the case of AHCCCS retro-eligibility, the date of the eligibility posting, whichever is later. A CRS Regional Contractorôs claims payment system, as well as the prior authorization and concurrent review process, must minimize the likelihood of having to recoup previously paid claims. Any individual recoupment in excess of $50,000 per provider within a contract year must be approved in advance by CRSA. CRSA must be notified of any cumulative recoupment greater than $50,000 per provider per contract year. A CRS Regional Contractor shall not recoup monies from a provider later than 12 months after the date of original payment on a clean claim, without prior approval from CRSA, unless the recoupment is a result of fraud, data validation, or audits conducted by CRSA or the AHCCCSA, Office of Program Integrity.
2. CRS providers are reimbursed for covered services by CRS Regional Contractors. CRS Regional Contractors are responsible for the processing and adjudication of claims presented by CRS providers according to the terms of their contracts with those providers. CRS Regional Contractors shall ensure that 90% of all clean claims are paid

within 30 days of receipt of the clean claim and 99% are paid within 60 days of receipt of the clean claim. The receipt date of the claim is the date stamp on the claim or the date electronically received. The receipt date is the day the claim is received at the CRS Regional Contractorôs specified claim mailing address. The paid date of the claim is the date on the check or other form of payment. [42 CFR 447.45(d)]

3. CRS Regional Contractors submit claims and encounter information to ADHS for program and financial management purposes. The complete, accurate, and timely reporting of encounter data is crucial to the success of the CRS program. CRSA uses encounter data to pay reinsurance benefits, set capitation rates, and to determine compliance with performance standards. CRS Regional Contractors shall submit encounter data to CRSA for all services for which the CRS Regional Contractor incurred a financial liability. Paid claims should be reconciled to the encounters to ensure that all paid claims have been encountered to CRSA.
4. Remittance advices accompanying CRS Regional Contractorôs payments to providers must contain, at a minimum, adequate descriptions of all denial and adjustments, the reasons for such denials and adjustments, the amount billed, the amount paid, and their right to file a claim dispute. (See Section 50.500)
5. Fast payment discounts and slow payment penalties shall be applied as of 07/01/06 as follows:
   A. For hospital clean claims paid within thirty days of the date the clean claim was received, the CRS regional contractor shall pay ninety-nine percent of the rate.
   B. If the hospital's clean claim is paid after thirty days but within sixty days of the date the clean claim was received, the CRS regional contractor shall pay one hundred percent of the rate.
   C. If the hospital's clean claim is paid any time after sixty days of the date the clean claim was received, the CRS regional contractor shall pay one hundred percent of the rate plus a fee of one percent per month for each month or portion of a month following the sixtieth day of receipt of the clean claim until the date of payment. When a fee is paid, the subcontractor must report the fee separately from the health plan paid amount on the encounter. The fee should be reported in the 837 CAS adjustment loop using reason code ñ85ò.
6. The CRS Regional Contractorsô claims receipt guidelines shall be as follows:
   A. Initial receipt of claims must be within six months of the claim submission dates described in 50.200.1, unless a shorter time period is specified in contract.
   B. Claims received beyond the six-month time frames defined above shall be denied.

C. For claims received within the six-month time frame, the provider has up to twelve months from the date of service to resubmit a clean claim.
D. Claim receipt requirements pertain to both contracted and non-contracted providers.

7. CRS Regional Contractors are required to accept HIPAA compliant electronic claims transactions from any provider interested and capable of electronic submission; and must be able to make claims payments via electronic funds transfer. CRS Regional Contractors shall monitor the ratio of electronic claims to hard copy claims received into the claims processing system, the ñtime to processò electronic claims versus hard copy claims, the effect that the volume of electronic claims processing has on claims processing metrics, and the effect that electronic claims processing has on the CRS Regional Contractors quality standards (goals). In addition, CRS Regional Contractors shall implement and meet the following milestones in order to make claims processing and payment more efficient and timely:
   A. CRS Regional Contractors must be able to make claims payments via electronic Funds Transfer by June 30, 2006; and
   B. CRS Regional Contractors are required to receive and pay 25% of all claims (based on volume of actual claims excluding claims processed by Pharmacy Benefit Managers (PBMs) electronically by June 30, 2006.
8. The CRS Regional Contractors shall develop and maintain an electronic health information system that collects, integrates, analyzes and reports data. The system shall provide information on areas including, but not limited to, service utilization, claim disputes and appeals. [42 CFR 438.242(a)] The CRS Regional Contractors will ensure that changing or making major upgrades to the information systems effecting claims processing, or any other major business component, will be accompanied by a plan which includes a timeline, milestones, and adequate testing before implementation. At least seven months before the anticipated implementation date, the CRS Regional Contractors shall provide the system change plan to CRSA for review.
9. Claims submitted to the CRS Regional Contractors shall include:
   A. Completion of all fields on the appropriate claim forms;
   B. The Provider Services Requisition (PSR) authorization number;
   C. Valid service-specific diagnostic and procedural codes;
   D. Usual customary charges, which shall be broken out for each valid code submitted;
   E. Accurate modifiers, where appropriate;
   F. Operative report for surgical procedures;
   G. Physiciansô orders and progress notes for durable medical equipment (DME);

H. All supportive documentation (reports, progress notes, orders) for services other than surgery (e.g. ICU visits, consultations, admissions); and

I. All Explanations of Benefits (EOB) that relate to the claim (CRS is the payor of last resort).

10. Claims submitted without the above information or with inaccurate codes will automatically be returned to the provider for proper resubmission or other disposition.

11. CRS Regional Contractors shall have an audit process and policy in place to identify claims that are overpaid or underpaid and a process to recover overpayments and to resolve underpayments within 12 months of the initial payment.

A. CRS Regional Contractors shall conduct monthly audits of adjudicated claims to identify claims processing errors and erroneously paid claims. The claims audited will be:

i. A random selection of 5% of adjudicated claims;

ii. Actual adjudicated claims for Professional, Facility (Inpatient and Outpatient), Dental and Pharmacy.

B. CRS Regional Contractors shall utilize the Overpayment and Underpayments Tracking Log (see 12.D. below) and the results of audited adjudicated claims (see 11. A.) to analyze the causes of processing errors, overpayments, and underpayments and develop and implement interventions to reduce the number and causes of errors, overpayments, and underpayments.

C. CRS Regional Contractors shall make timely revision to claims processing policies and processes based on any interventions identified in 11. B. and submit any revised policies and procedures to CRSA with the Quarterly Overpayments and Underpayments Log within ninety (90) days of the policy and procedure changes.

D. CRS Regional Contractors shall notify CRSA immediately if the contractor is planning to recoup from any one provider an amount which will bring the total contract year net recoupment for that provider to an amount over $50,000.

E. CRS Regional Contractors shall implement a policy for the methods of recoupment and/or adjustment of a claim overpayment. CRSA approved methods of recoupment/adjustment are:

i. Reduction of subsequent providerôs payment if funds allow, or

ii. Requested refund of overpayment, (see sample refund letter), if providerôs account is not sufficient to accommodate reduction of payment.

F. CRS Regional Contractors shall implement a policy for the adjustment of underpayment of claims. The CRSA approved

method of adjusting underpayment of claims is to adjust the provider's payment (within 12 months of the original claim payment date) and to include notation of the adjustment within the remittance advice.

G. CRS Regional Contractors shall void/adjust the original encounter when a recoupment is made due to the identification of an erroneously paid claim (claim that should have originally been denied) or when a recoupment is made due to incorrect data or processing, e.g., when demographic, clinical or financial data is changed).

12. The following reports are due to CRSA on a monthly/quarterly basis or more frequent if requested by CRSA.
    A. Monthly Claims Aging Reports listing the amount of claims received and the length of time they have been in the CRS Regional Contractor's system to be paid. (Three monthly reports can be submitted each quarter.)
    B. Monthly Claims Inventory Report listing total work-in-process comprised of unprocessed claims received from providers for adjudication. *Unprocessed claims* have not yet been paid, denied, or pended. This report should be a snapshot at the end of the month. (Three monthly reports can be submitted each quarter.)
    C. Monthly Pended Claims Report listing the amount of claims received that are pended, the reason they are pended (e.g., internal claims review), and the length of time they have been in the CRS Regional Contractor's system as pended. This report should be a snapshot at the end of the month. (Three monthly reports can be submitted each quarter.)
    D. Quarterly Overpayments and Underpayments Tracking Log Report containing elements as defined by CRSA (see attachment A at the back of this chapter).
    E. Monthly Claim to Encounter reconciliation containing elements as defined by CRSA (see attachment E at the back of this chapter). (Three monthly reports can be submitted each quarter.)
    F. Quarterly Deleted Encounters Log containing elements as defined by CRSA (see attachment F at the back of this chapter).
    G. Monthly Claims Accuracy/Data Integrity Report containing elements as defined by CRSA (see attachment G at the back of this chapter). (Three monthly reports can be submitted each quarter.)
13. Claims processing personnel shall be trained to process the CRS claims.

A. CRS Regional Contractors shall maintain personnel records that ensure the contractors claims processors are trained or certified as claims processors.
B. CRS Regional Contractors shall require the claims processors have current and up to date training on claims processing.
C. CRS Regional Contractors shall maintain a Claims Processing Training log to be provided to CRSA quarterly or more frequently if requested by CRSA (see attachment B at the end of this chapter).
D. CRS Regional Contractors shall maintain sign-in sheets (see attachment C at the end of this chapter), training log and associated materials for all in-service training sessions.
E. CRS Regional Contractors shall have a representative attend the AHCCCS Quarterly Encounter Meetings on a regular basis.
F. CRS Regional Contractors shall maintain current and complete copies of the AHCCCS Claims Clues and Encounter Keys publications and sign-off distribution lists of all personnel responsible for AHCCCS claims/encounter processing or pend correction, ensuring the AHCCCS claim/encounter processing or pend correction personnel have read the information provided within the publications. Copies of the sign-off distribution lists shall be provided to CRSA at the annual site review.
G. CRS Regional Contractors shall implement any major changes in CRS claims and/or encounter processing as defined by CRSA as a result of information provided in the Claims Clues and Encounter Keys publications.
H. CRS Regional Contractor claims processing personnel shall complete all claims and/or encounter processing training provided by CRSA.

## 50.300 Collecting Payments for CRS Services

This section pertains to the requirements for CRS Regional Contractors obtaining payment for services provided to CRS members. This includes coordination of benefits and member responsibilities. CRSA requires CRS Regional Contractors to be responsible for coordination of benefits for services provided. The two methods used in the coordination of benefits are cost avoidance and post-payment recovery.

### 50.301 Coordination of Benefits

1. Since the State of Arizona is the payor of last resort for the state only CRS population while AHCCCS is, in most instances, the payor of last resort for the AHCCCS CRS population, the CRS program, as funded by the state and AHCCCS, shall be used as a source of payment for

covered services only after all other sources of payment have been exhausted. CRS Regional Contractors shall coordinate benefits in accordance with 42 CFR 433.135 et. seq., A.R.S. §36-2903, and A.A.C. R9-22-1001 et. seq. so that costs for services otherwise payable by CRS Regional Contractors are cost avoided or recovered from a liable first or third-party payer. CRS Contract Providers are to make all reasonable efforts to collect from insurance companies and other third party payors.

2. CRS Regional Contractors shall take reasonable measures to determine the legal liability of third parties who are liable to pay for covered services. CRS Regional Contractors shall cost-avoid a claim if it establishes the probable existence of a third party or has information that establishes that third party liability exists. However, if the probable existence of third party liability cannot be established or third party liability benefits are not available to pay the claim at the time the claim is filed, the CRS Regional Contractor must process the claim. If a CRS Regional Contractor knows that the third party insurer will not pay the claim for a covered services due to untimely claim filing or as the result of the underlying insurance coverage (e.g., the service is not a covered benefit), the CRS Regional Contractor shall not deny the service, deny payment of the claim based on third party liability, or require a written denial letter if the service is medically necessary. The CRS Regional Contractor is required to reimburse providers for previously recouped monies if the provider was subsequently denied payment by the primary insurer based on untimely filing limits or lack of prior authorization and the member failed to disclose additional insurance coverage other than AHCCCS.
3. If a member (other than a State Only 100% pay member) has insurance which covers the CRS services provided, the member (other than a State Only 100% pay member) shall not be billed the residual, regardless of the memberôs payment responsibility.
4. A CRS Regional Contractor is responsible for collecting payments from insurance companies, managed care organizations and all other third party payers in accordance with member and family insurance policies, the CRS Contractorôs contractual arrangements with the payers, and all applicable Arizona statutes.
5. AHCCCS requires that all AHCCCS members with a CRS eligible medical condition, without private insurance, enroll with CRS. For those members with a CRS eligible condition, with private insurance, enrollment with CRS shall be optional. AHCCCS Members with private insurance choosing not to enroll with CRS may seek the payment of applicable copays and deductibles from the AHCCCS health plan/program contractor with whom they are enrolled. When the private insurance is exhausted with respect to CRS covered conditions, the AHCCCS health plan/program contractor is required to refer the

member to CRSA for determination for CRS services. For those members with private insurance who are enrolled in the CRS program, the CRS Regional Contractors are responsible for applicable copays and deductibles related to the CRS condition. CRS Regional Contractors are not responsible for paying coinsurance and deductibles that are in excess of what the CRS Regional Contractor would have paid for the entire service per a written contract with the provider performing the service, or the AHCCCS Fee For Service (FFS) payment equivalent. If the CRS Regional Contractor refers the member for services to a third-party insurer (other than Medicare), and the insurer requires payment in advance of all co-payments, coinsurance and deductibles, the CRS Regional Contractor must make such payments in advance.

6. When services are provided by the CRS program, which are outside the covered benefits provided by the insurer, the insurer is not required to pay for those services. If the member is a State Only 100% pay member, the family or member is responsible to pay for the services not covered by third party insurance according to what the CRS Regional Contractor would have paid for the entire service per a written contract with the provider performing the service, or the AHCCCS Fee For Service (FFS) payment equivalent.
7. If the CRS Regional Contractor does not know whether a particular service is covered by the third party, and the service is medically necessary, the CRS Regional Contractor shall contact the third party and determine whether or not such service is covered rather than requiring the member to do so. In the event that the third party does not cover the service, the CRS Regional Contractor shall arrange for the timely provision of the service.
8. The requirement to cost-avoid applies to all CRS covered services. In emergencies, the CRS Regional Contractor shall provide the necessary services and then coordinate payment with the third-party payer. Further, if a service is medically necessary, the CRS Regional Contractor shall ensure that its cost avoidance efforts do not prevent a member from receiving such service and that the member (other than a State Only 100% pay member) shall not be required to pay any coinsurance or deductibles for use of the other insurerôs providers.
9. The amount of the payment due from the insurer or other third party payor is as follows:
    A. Third party payors not included as health care services organizations as described under Title 20, Chapter 4, Article 9 shall be billed the providerôs usual and customary charges with payments subject to the payorôs requirements for deductible and coinsurance.
    B. If a third-party insurer (other than Medicare) requires the CRS member to pay any co-payment, co-insurance, or deductible, the CRS Regional Contractor is responsible for making these

payments, even if the services are provided outside of the CRSA network.

C. CRS Regional Contractors are generally responsible for payment of Medicare coinsurance and/or deductibles for covered services provided to dual eligible members. However, there are different cost sharing responsibilities that apply to dual eligible members based on a variety of factors. CRS Regional Contractors are responsible for adhering to the cost sharing responsibilities presented in the *AHCCCS Contractors Operations Manual (ACOM), Chapter 200, Claims, Medicare Cost Sharing for Members in Medicare FFS/HMO* (See http://www.ahcccs.state.az.us/Publications/GuidesManuals/ACOM/ACOM.pdf ). CRS Regional Contractor shall have no cost-sharing obligation if the Medicare payment exceeds what the CRS Regional Contractor would have paid for the same service of a non-Medicare member.

10. CRS Regional Contractors shall not bill AHCCCS Health Plans for CRS services.
11. Post-payment recovery is necessary in cases where the CRS Regional Contractor was not aware of third-party coverage at the time services were rendered or paid for, or was unable to cost-avoid. The CRS Regional Contractor may retain up to one hundred percent (100%) of its third-party collections if all of the following conditions exist:
    A. Total collections received do not exceed the total amount of CRSA financial liability for the recipient;
    B. There are no payments made by AHCCCS related to fee-for-service, reinsurance or administrative costs (i.e., lien filing, etc.); and,
    C. State or federal law does not prohibit such recovery.
12. The CRS Regional Contractor shall identify all potentially liable third parties and pursue reimbursement from them except the CRS Regional Contractor shall not pursue reimbursement for Title XIX and Title XXI enrolled CRS members in the following circumstances unless the case has been referred to CRSA by AHCCCS or AHCCCSôs authorized representative:
    A. Uninsured/ underinsured motorist insurance;
    B. First and third party liability insurance;
    C. Tortfeasors, including casualty
    D. Restitution recovery;
    E. Workerôs compensation;
    F. Estate recovery; and,
    G. Special treatment trust recovery.
13. The CRS Regional Contractor shall report to CRSA all cases for which:

A. The CRS Regional Contractor identifies circumstances A through G above.
B. The CRS Regional Contractor shall cooperate with AHCCCSôs authorized representative in all collection efforts.

14. The CRS Regional Contractor may be required to report case level detail of third-party collections and cost avoidance including number of referrals on total plan cases. The CRS Regional Contractor shall communicate any known change in or addition to health insurance information, including Medicare, to CRSA, not later than 10 days from the date of discovery using AHCCCS approved correspondence or AHCCCS approved Third-Party Correspondence.

## 50.302 Member Responsibility

A. A member shall participate in the cost of care by paying for services in the amounts described in Chapter 20, Member Payment Responsibility Standards.
B. The CRS Regional Contractor shall be responsible for collecting co-payments specified in Chapter 20, Member Payment Responsibility Standards. Any required co-payments collected shall belong to the CRS Regional Contractor or providers.
C. Except for permitted co-payments, the CRS Regional Contractor or providers shall not bill or attempt to collect any fee from, or for, an AHCCCS recipient for the provision of covered services.
D. The CRS Regional Contractor shall ensure that a member with a payment responsibility category of less than or equal to 200% FPL is not denied services because of that memberôs inability to pay a co-payment or deductible.
E. The CRS Regional Contractor is responsible for collecting applicable payment amounts from members with a payment category of greater than 200%FPL. The CRS Regional Contractor shall not deny services because of a memberôs inability to pay a co-payment or deductible for State Only 100% pay members who have a third party insurance.
F. The CRS Regional Contractors may recover from a member what the CRS Regional Contractor has paid a provider up to the payments made by a third party payor to the member. The amount recovered from the member should not exceed the amount that the CRS Regional Contract paid to the provider. The CRS Regional contractor would not recover from a member if the third party payor assigned payment to the CRS Regional Contractor.
G. Claims for CRS services shall not exceed the CRS Regional Contractorôs or the subcontractorôs usual and customary rates.
H. A CRS Regional Contractor may bill a member or family for medical expenses incurred during a period of time when the member or family willfully withholds material information from the CRS Regional

Contractor or provides false information pertaining to CRS, AHCCCS, KidsCare, or private insurance eligibility or enrollment status that results in denial of payment due to failure to disclose such information or the provision of false information.

I. The CRS Regional Contractors or their designees must adhere to the prior authorization requirements of all health service organizations. Neither families nor the CRS Program are responsible for the payment of services where payment was denied by a third party payor due to the fact that the CRS Regional Contractor failed to comply with preauthorization or other utilization management procedures.

## 50.400 Denied Claims

1. CRS Regional Contractors will provide written notifications to providers for all claims that are denied in part or for which a partial payment is made.
2. Notifications must contain:
   A. Date of denial;
   B. Services being denied or not included in payment;
   C. Reason for the denial or reduction in payment; and
   D. Providersô right to file a claim dispute and how to do so.

## 50.500 Claim Dispute Process

### 50.501 Time Frame for Filing Claim Dispute

Claim disputes must be filed in writing with the CRS Regional Contractor no later than 12 months from the date of service, within 12 months of the date that AHCCCS eligibility is posted or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later. See ARS 36-2903.01 (B) (4)

### 50.502 Claim Dispute Policy and Process

1. CRS Regional Contractors shall have in place a written claim dispute policy for providers regarding adverse actions taken by the CRS Regional Contractor. The policy shall be in accordance with applicable Federal and State laws, regulations and policies.
2. The Provider Claim Dispute policy shall be provided to all subcontractors at the time of contract. For providers without a contract, the claim dispute policy must be sent no later than 45 days of receipt of a claim.
3. All documentation received by the CRS Regional Contractor during the claim dispute process shall be dated upon receipt. Specific individuals shall be appointed with requisite experience to administer the claim dispute process. Each claim dispute shall be thoroughly

investigated using the applicable statutory, regulatory, contractual and policy provisions, ensuring that facts are obtained from all parties. All claim disputes with the appropriate documentation shall be filed separately in a secure designated area and shall be retained in a reproducible format for five years following the CRS Regional Contractorô decision, the Administrationôs decision, judicial appeal or close of the claim dispute, whichever is later, unless otherwise provided by law. Each claim dispute file must contain documentation of the written claim dispute, acknowledgment letter, all documentation received during the claim dispute process, request for extension of decision (if applicable), other information relevant to the notice of decision of the claim dispute, notice of decision letter, documentation of reprocessing and paying the claim within ten business days of the date of the Decision (if the claim dispute is overturned), providerôs written hearing request (if applicable), and hearing request cover letter to AHCCCS (if applicable).

4. CRS Regional Contractors are required to track, trend and analyze claim disputes for purposes of detecting fraud and/or abuse and system improvement. Any suspected fraud and abuse detected must be reported consistent with the requirements in Chapter 80, Section 302 of this manual.

## 50.503 Filing a Claim Dispute

1. For a claim for CRS services rendered to a member, the provider shall file a written claim dispute with the CRS Regional Contractor under the timelines in this policy. A claim dispute shall specify in detail the factual and legal basis for the claim dispute and the relief requested.
2. Within five working days of receipt, the Provider shall be informed by letter that the claim dispute has been received.
3. The CRS Regional Contractor shall mail a written Notice of Decision of the claim dispute to the provider no later than 30 calendar days after the provider files the claim dispute with the CRS Regional Contractor, unless the provider and the CRS Regional Contractor agree to a longer period. Documentation of an extension of time must be maintained in the claim dispute file.
4. The CRS Regional Contractorôs written Notice of Decision shall include:
   A. The nature of the claim dispute
   B. The issues involved
   C. The reasons supporting CRS Regional Contractorô Decision, including references to applicable statute, rule, applicable contractual provisions, policy and procedure
   D. The Providerôs right to request a hearing by filing a written request for hearing to CRS Regional Contractor no later than

30 days after the date the Provider receives CRS Regional Contractorôs decision.

E. If the claim dispute is overturned, it is required that the CRS Regional Contractor shall reprocess and pay the claim in a manner consistent with the Decision within ten business days of the date of the Decision. The CRS Regional Contractor shall have a process for internal communication and coordination when an appeal or claim dispute decision is reversed.

5. If the Provider files a written request for hearing, CRS Regional Contractor must ensure that all supporting documentation is received by the AHCCCS, Office of Legal Assistance, no later than five working days from the date the CRS Regional Contractor receives the providerôs written hearing request from AHCCCS, Office of Legal Assistance. The file above sent by CRS Regional Contractor must contain a cover letter that includes:
   A. Providerôs name
   B. Providerôs AHCCCS ID number
   C. Providerôs address
   D. Providerôs phone number (if applicable)
   E. The date of receipt of claim dispute
   F. A summary of CRSA or its subcontractorsô actions undertaken to resolve the claim dispute and basis of the determination
6. The following material shall be included in the file noted in step # 5 sent by CRS Regional Contractor:
   A. Written request for hearing filed by the Provider
   B. Copies of the entire file which includes pertinent records; and CRS Regional ContractorsôDecision
   C. Other information relevant to the Notice of Decision of the claim dispute
7. If CRS Regional Contractorsô decision regarding a claim dispute is reversed through the appeal process, CRS Regional Contractors shall reprocess and pay the claim in a manner consistent with the decision within ten business days of the date of the decision.
8. A provider claim dispute log shall be maintained for all claim disputes and provided to CRSA on a monthly basis (see attachment D at the end of this chapter).